

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11640 245

1. PLACE OF DEATH:

County Prince George's CountyCity or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 YearsHospital, institution, or street address where death occurred:
5405 35th AvenueHow long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 5405 35th Avenue
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

DAVID MARSDEN ANDERSON SR.

3. (b) Social Security Number

177-14-6722

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife Stella Anderson7. Birth date of deceased (mo., day, yr.) October 26, 18676. (c) If alive, give age -- years8. AGE: Years 81 Months 0 Days 19 If less than one day
hrs. min.9. Birthplace Fayetteville, North Carolina.
(Town, county, and state)10. Usual occupation Manufacturing Representative11. Industry or business W.F. Hessell, New York City12. Name David Anderson13. Birthplace North Carolina14. Maiden name Mary Wiley15. Birthplace North Carolina16. Informant Mr. David M. Anderson Jr.Address 5405 35th Ave., Hyattsville, Md.17. BURIAL Date thereof Nov. 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or ~~XXXX~~ Fort Lincoln CemeteryLocation Prince George's County, Md.18. Funeral director W. W. CHAMBERS COMPANYAddress 5801 Cleveland Ave., Riverdale, Md.19. Nov 8 1948 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1948 at 6:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7/22 1948 to Nov 6 1948
and that I last saw him alive on Nov 6 1948Immediate cause of death Cerebral Aneurysm DURATION

Due to

Due to

Other conditions Subarachnoid Aneurysm

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE AARON DIETZ M. D. or otherAddress 4314 Gallatin Street Date signed 11-6-48Hyattsville, Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 9 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11642

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince Geo.
 City or town Lanesh (Warren's Hospital)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

82

2

19

hrs.

min.

Franklinville, Md.

(Town, county, and state)

Housewife

Home

John M. Vogts

Germany

Germany

Edmund A. Vogts

Lanesh, Md.

Burial

Date thereof

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Le Witt Donaldson

Lanesh, Md.

Address

Nov 2

1948

M. Brashears

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Lanesh
(If outside city or town limits, write RURAL and give nearest town)Street No. 25 Post office Avenue
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 1 1948 at 12:05 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 27 1948 to 10-31 1948and that I last saw her alive on 10 31 1948

Immediate cause of death

Total

Pneumonia

Due to

Myocardial failure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

11-2-48

M. D. or other

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1948
66
82



PLEASE WRITE IN MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64

11643

Reg. Dist. No. 239

1. PLACE OF DEATH:

Prince George
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 603 Main Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Ingalls Barker

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

M W Infant

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6, 1948

8. AGE: Years Months Days If less than one day
2 14 hrs. min.

9. Birthplace Laurel, Po. Geo. Maryland
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Mr. John P. Barker13. Birthplace Annes, Iowa14. Maiden name Marjorie Wheeler15. Birthplace Jefferson, New Hampshire16. Informant Mr. John P. BarkerAddress 603 Main St, Laurel, Md.17. Burial Date thereof Nov. 22, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Headwinds Green ParkLocation Laurel, Maryland18. Funeral director Dr. W. H. DonaldsonAddress Laurel, Maryland19. Nov. 21 19 48 M. Breakers

(Date rec'd by registrar) T Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 19 48 at 2 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 19 48 to Nov 20 19 48and that I last saw him alive on 19

Immediately cause of death

Staphylococcussymplicus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

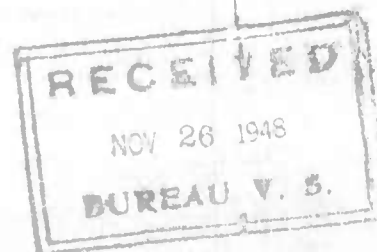
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Warren M.D.Address Laurel Date signed 11/20/48



PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County..... Prince Georges Co.
 City or town..... Berwyn
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Pr. Georges

City or town..... Berwyn
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 5016-Quebec Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ruth Howell Bowie Beck

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife

James M Beck

7. Birth date of

deceased (mo., day, yr.)

January 8, 1893

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

55

hrs.

min.

9. Birthplace

Washington

D.C.

(Town, county, and state)

10. Usual occupation

Retired clerk

11. Industry or business

FATHER

12. Name

George S Howell

13. Birthplace

Washington

D.C.

14. Maiden name

Martha Jane Howell

15. Birthplace

Washington

D.C.

18. Informant

George F. Beck

Address

3942- C Street S.E.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Dec. 1, 1948

(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Suitland, Maryland

18. Funeral director

Wm J. Nalley

Address

3200-R.I. Ave. Mt. Rainier, Md.

19. Pro-Bo

(Date rec'd by registrar)

19

48 James Berry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 28

19

48

at

11

P

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1

19

44

to

Nov 28

19

48

and that I last saw him alive on

Nov 28

19

48

Immediate cause of death

Cerebral hemorrhage
Hypertension and
arteriosclerosis

DURATION

4 hours

4 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert B Bacon MD

Address

Suite 107 Burlington Hotel

Date signed

11/30/48

RECEIVED

DEC 4 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11645

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
 City or town Bladensburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrsHospital, institution, or street address where death occurred: 4610 Annapolis Rd.How long in hospital or institution? 2 days

3. (a) FULL NAME

Annie Bell4. Sex 7 5. Color or race C 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband Samuel Bell

(deceased)

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 18768. AGE: Years 72 Months 1 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Domestic11. Industry or business Homemaker12. Name William Harrison13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Mrs. Bertha JeffersonAddress 4610 - Annapolis Rd. Bladensburg17. Burial (Burial, cremation, or removal, which) BurialDate thereof Nov. 13, 1948

(month) (day) (year)

Cemetery or crematory PaynesLocation Washington, D.C.19. Funeral director John J. StewartAddress 301 N. St. N.E. Wash., D.C.20. Date rec'd by registrar Nov. 11, 1948Registrar Carrie F. Campbell

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P. G.City or town Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4610 - Annapolis Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1948 at 2:30 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30, 1948 to Nov. 9, 1948and that I last saw him or her alive on Nov. 7, 1948Immediate cause of death MyocardialAcuteDURATION 2 daysDue to Toxemia fromNephritisDUE TO 26 noOther conditions Nephritis, Cystitis, 26 no

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thos. E. Spiller M.D.Address Brentwood, Md.Date signed 11-9-48

RECEIVED

NOV 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 240

11646

159

1. PLACE OF DEATH:

County Prince GeorgesCity or town Waldorf
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Waldorf
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Baby Brookes

3. (b) Social Security Number

4. Sex

male

5. Color or race

Caucas

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Nov 1, 1948

8. AGE:

Years

Months

Days

If less than one day

2 hrs. 30 min.

9. Birthplace

Waldorf, Md
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name

Joseph H. Brookes

13. Birthplace

Maryland

14. Maiden name

Burnell Smith

15. Birthplace

Maryland

16. Informant

Joseph H. Brookes

Address

Waldorf, Md

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof 11-2-1948
(month) (day) (year)

Cemetery or crematory

On Dawson Farm

Location

Near Waldorf in Prince Georges Co

18. Funeral director

Joseph D. Brookes

Address

Waldorf Md R.F.D.

19.

Nov. 2
(Date rec'd by registrar)1948J. H. Billingsley
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1, 1948 at 3:30 P M

21. I CERTIFY that death occurred on the date above elated; that I attended deceased from

19____, to 19____

and that I last saw him alive on 19____

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M.D. or other

Date signed 11-2-48

B21
+ B20

12-15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11647

CERTIFICATE OF DEATH

Reg. Dist. No. 231

FILM No. G 118 NOV 24 1948

1. PLACE OF DEATH:

County Prince George General
 City or town Cheverly, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 36 hours
 Hospital, institution, or street address where death occurred:
Prince George General
 How long in hospital or institution? 36 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4400 - 28th Place
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Kathleen Mary Burgess

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife Henry S. Burgess7. Birth date of deceased (mo., day, yr.) November 17 18998. AGE: Years Months Days If less than one day
50 5 11 23 hrs. min.9. Birthplace P. C.
 (Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name James Mulvey13. Birthplace Pennsylvania14. Maiden name Mary

15. Birthplace

16. Informant Henry BurgessAddress 4400 - 28th Place
Mt. Rainier Md17. Burial Date thereof Nov 12, 1948
 (Burial, cremation, or removal? (month) (day) (year))Cemetery or crematory St. LincolnLocation Colman Manor Md18. Funeral director J. EschersonAddress Nyassville Md19. Nov 11 19 48 Amanda Worey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 19 48 at 6 40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 10 19 46 to Nov 10 19 48
 and that I last saw him alive on November 19 48

Immediate cause of death

DURATION

Cerebral AccidentDue to followingDue to cholecystectomy

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. L. D. M. D. or otherAddress H. H. L. D. Date signed 11-11-48

RECEIVED

NOV 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11648 7265

1. PLACE OF DEATH: County <u>Prince Georges County</u> City or town <u>Hyattsville Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>45 years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Prince Georges</u> City or town <u>Hyattsville Maryland</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>6004</u> <u>44th avenue</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Noma Mead Burrhus</u>				3. (b) Social Security Number			
4. Sex <u>female</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>widowed</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Frederick C. Burrhus</u>				2D. DATE OF DEATH <u>November 15, 1948</u> at <u>3:30 P.M.</u>			
7. Birth date of deceased (mo., day, yr.) <u>May 8, 1875</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1948</u> to <u>Nov 15 1948</u> and that I last saw <u>her</u> alive on <u>Nov. 13, 1948</u>			
8. AGE: Years <u>73</u>		Months		Days		Immediate cause of death <u>Cerebral Thrombosis</u>	
				If less than one day hrs. min.		DURATION <u>3 days</u>	
9. Birthplace <u>Ohio</u> (Town, county, and state)				Due to <u>General arteriosclerosis</u>			
10. Usual occupation <u>housewife</u>				Due to <u>Congestive Heart Failure</u>			
11. Industry or business <u>Truman Oliver Mead</u>				Other condition <u>arteriosclerotic Heart Dis.</u>			
12. Name <u>Ohio</u>		13. Birthplace <u>Ohio</u>		(Include pregnancy within 3 months of death)			
14. Maiden name <u>Mary Chaffee</u>		15. Birthplace <u>Ohio</u>		Major findings of operations Date of op.			
16. Informant <u>Mr. Harold Burrhus</u> Address <u>Hyattsville Maryland</u>				Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial Date thereof <u>Nov. 18, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>St. Lincoln Cemetery</u> Location <u>Colmar manor Maryland</u> Funeral director <u>F. Gasch's Sons</u> Address <u>Hyattsville Maryland.</u>				22. VIOLENCE: If death was due to external cause, fill in the following: Accident, suicide, or homicide. Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
18. (Date rec'd by registrar) <u>Nov 17 1948</u>				23. SIGNATURE <u>J. Q. Schaffenberg Jr. M.D.</u> <u>4404 Queensbury Rd., Rivindale</u>			
19. Registrar <u>J. Louis Serey</u>				Date signed <u>11-16-48</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11649 245

1. PLACE OF DEATH:

County Prince George Co MdCity or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Sacred Heart Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince GeorgesCity or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Julia Burns

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

✓

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

March 29, 1859

8. AGE:

Years

Months

Days

If less than one day

89727hrs.min.

9. Birthplace

Quebec Canada
(Town, county, and state)

10. Usual occupation

Houseworker

11. Industry or business

FATHER

12. Name

William Burns

13. Birthplace

Quebec Canada

MOTHER

14. Maiden name

Julia Cullier

15. Birthplace

Quebec Canada

16. Informant

James Atheris

Address

2816 N. Franklin Arlington Va

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov 30, 1948
(month) (day) (year)

Cemetery or crematory

Laurel Cemetery

Location

Laurel Md.

18. Funeral director

Cherry Chase Funeral Home

Address

5701 Wisconsin Washington D.C

19. Nov-27

(Date rec'd by registrar)

1948

James Devay

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948, at 10:40 PM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Nov 18 48 Nov 26 48
and that I last saw him alive on Nov 26 48

Immediate cause of death

DURATION

Coronary artery sclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert C. Hale MD

M. D. or other

Address

35 N. York Ave

Date signed

27 Nov 48

CERTIFICATE OF DEATH

RECEIVED

NOV 30 1948

BUREAU V. S.

PLEASE WRITE FAIRLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

11650

245

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince GeorgeCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4411-30th St. Mt. Rainier Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Prince GeorgeCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4411-30th St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Florence E. Chaney

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband

Wm. H. Chaney

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Aug 17th 1875

8. AGE:

Years

Months

Days

If less than one day

73

hrs.

min.

9. Birthplace

Washington D. C.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

William May

13. Birthplace

Wash. D. C.

14. Maiden name

Elizabeth Taylor

15. Birthplace

Wash. D. C.

16. Informant

Mrs. Florence Chaney

Address

4411-30th St. Mt. Rainier Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

11-9-1948
(month) (day) (year)

Cemetery or crematory

St. Lincoln

Location

Wash-Balto Blvd + D. C. Line Md.

18. Funeral director

Wm. J. Galley

Address

3200-R. J. Ave. Mt. Rainier Md.

19.

Nov-8
(Date rec'd by registrar)

19.

48 James Sever

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

11-619 48at 7:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-1919 48to 11-619 48

and that I last saw him alive on

11-119 48

Immediate cause of death

Fracture of RightFemur (extrathoracic)Pneumothorax on Right

DURATION

4 1/2 mo.

Due to

Due to

Other conditions

Hypertensive CardioNervous System Sensitivity

(Include pregnancy within 3 months of death)

2 yrs

Major findings of operations

Extrathoracic FractureRt. Hip. Bone FracturedDate of op. 6-21-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

AccidentDate of 6-19-48

Where did injury occur?

Mt. Rainier
(City or town)Md.
(State)

Injured at home, farm, industry, public place (where?)

Sidewalk at home

Means of injury

Fall

Injured at work?

home

23. SIGNATURE

W. J. GalleyMd.

M. D. or other

Address

Mt. Rainier Md.Date signed 11-6-48

RECEIVED

NOV 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11651

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George's
City or town Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 44 years

Hospital, institution, or street address where death occurred:

715 - 58 AvenueHow long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)Street No. 715 - 58 Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHARITY, SADIE QUANDER

3. (b) Social Security Number

7

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

CHARITY, MALKIAH6. (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.)

November 20, 1881

8. AGE:

66 Years11 Months16 DaysIf less than one day
..... hrs. min.

9. Birthplace

Alexandria, Virginia
(Town, county, and state)

10. Usual occupation

Public School Teacher and Housewife

11. Industry or business

12. Name

Quander, Robert

13. Birthplace

Fairfax, Virginia

14. Maiden name

Topp, Fermina

15. Birthplace

Virginia

16. Informant

Jenkins, Virginia

Address

4227 Edmonston Ave, Bladensburg, Md17. 11-10-48 Date thereof

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Chapin Mt. Church

Location

Landrum Wd

18. Funeral director

James W. Edmonson

Address

2006 - 9th St. N.W.19. Nov 7 19 48

(Date rec'd by registrar)

Amanda Howard

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 19 48 at 1:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 6 19 46 to Nov. 7 19 48and that I last saw him alive on Nov. 7 19 48Immediate cause of death nephrosclerosis DURATION(uremia) 2 yrsDue to Arteriosclerosis ?Due to Hypertensive cardio- ?vascular renal diseaseOther conditions Diabetes mellitus 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

2. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE

Theodore Pinckney M.D.4832 D Lane Ave NE M. D. Address Washington D.C. Date signed Nov. 7, 1948

MARGIN RESERVED FOR BINDING

I

9-45-15M

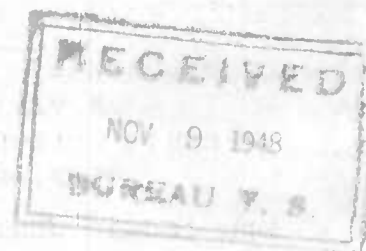
VS A15

PLEASE WRITE FAIRLY, WITH UNFADING INK. Supply every item of information care. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 15 1948

BUREAU V. 25.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11653
Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges
City or town near Glenarden
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? transit
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Pr. Georges
City or town Glenarden
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Virginia Harriet Chittams

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 19, 1906 6.(c) If alive, give age _____ years

8. AGE: Years 42 Months 10 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Automotive machinist

11. Industry or business Auto Parts

12. Name Wm. T. Chittams

13. Birthplace Ind.

14. Maiden name Mary G. Hubert

15. Birthplace Ind.

16. Informant Mari Chittams

Address Glenarden, Md

17. Removal Nov 20, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Melrose & Schy funeral home

Location 424 RST N. W. Washington St

18. Funeral director F. Sacchi Sons

Address Lythkensville Ind

19. Nov 20, 1948 Amanda D. Dorey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 19 48 at 10:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Due to Hemorrhage & shock

Due to Multiple fractures & lacerations of body

Other conditions Struck by automobile

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following:

Accident, suicide, or homicide Accident Date of 11-19-48

Where did injury occur? Near Glenarden, Ind (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Public Place

Means of injury Hit by automobile Injured at work? No

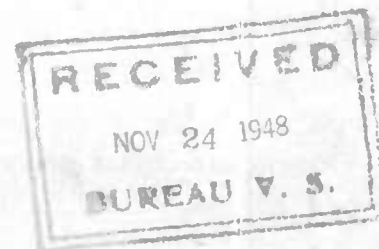
23. SIGNATURE John W. Maloney, M.D. Medical Examiner

Address Cherry Hill, Hyattsville, Md Date signed 11-20-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE MAINLY IN UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11654

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges Co
 City or town CLINTON, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sigrid H. Clifton

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas R. Clifton

7. Birth date of deceased (mo., day, yr.)

May 29 - 1880

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

68

hrs.

min.

9. Birthplace

Oslo Norway
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Rudolph Hesseberg

13. Birthplace

Norway

14. Maiden name

Karen Hobbensen

15. Birthplace

Norway

16. Informant

Thomas R. Clifton

Address

1523-Clisewood St NE

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Nov 9 - 1948
(month) (day) (year)

Cemetery or crematory

Ledar Hill Cemetery

Location

Suitland Maryland

18. Funeral director

Arthur E. Simmons

Address

2007 Nichols Ave SE

19.

Nov 10
(Date rec'd by registrar)

19.

48 Howard I Beall

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

WASHINGTON, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

1523-CLISERWOOD ST. NE
(If rural, give LOCATION)

2. (a) If veteran, name war

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 6

19.

45

at

5P

P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1

19.

45

to

Nov 6

19.

45

and that I last saw her alive on

Nov 5

19.

45

Immediate cause of death

Heart failure - withPulmonary edemaSecondaryAnemiaCoronary atherosclerosisuterus with metastasesOther conditions

DURATION

2 hours3 mo6 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Metastases fromCarcinoma of uterusDate of op. Oct 15, 48

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Natural causes

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul C. Han Datta

M. D. certificate

Address

Washington 1900

Date signed

Nov 7, 48

RECEIVED

NOV 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11641

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George's County
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Days 21 Hours
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 5 Days 21 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Prince Geo
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4018 Jefferson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Concklin, Mr. Arthur

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Helma Concklin
7. Birth date of deceased (mo., day, yr.) Sept 15, 1881 6.(c) If alive, give age _____ years
8. AGE: Years 67 Months 1 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER
12. Name Henry Concklin
13. Birthplace Washington D.C.
14. Maiden name Louisa Piers
15. Birthplace Washington D.C.

16. Informant Mrs Louise M. Heagy
Address Washington D.C.

17. Burial Date thereof Nov 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lincoln
Location Colmar Manor Md

18. Funeral director F. Casale sons
Address Hyattsville Md

19. Nov 8 48 Amanda W. Warrington
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 19 48 at 11:09 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-14-48 to 11-5-48
and that I last saw him alive on Nov 5 19 48

Immediate cause of death Coronary thrombosis DURATION 6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John P. Clum M.D.
M. D. or other

Address Hyattsville Md Date signed 11-6-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 9 1948

BUREAU V. S.

RECEIVED

NOV 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Princetown, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 97 daysHospital, institution, or street address where death occurred:
Deland Memorial HospitalHow long in hospital or institution? 97 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Colmar Manor - Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 3314-40th Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Miss Mary Sidney Cumberland

3. (b) Social Security Number

4. Sex female5. Color or race white6. (a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 18798. AGE: Years 69 Months 6 Days — If less than one day — hrs. — min. —9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation clerk

11. Industry or business

12. Name William Edward Cumberland13. Birthplace Washington D.C.14. Maiden name Annie E. Moore Cottrell15. Birthplace Washington D.C.16. Informant Mrs. Anna Shaker - nieceAddress 3314-40th Place - Colmar Manor Md.17. Burial Date thereof Dec. 4 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Colmar Manor, Prince Geo. Co.18. Funeral director Wm. J. HalleyAddress 3200 - R.I. Ave. Mt. Rainier, Md.19. Nov 30 1948 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 - 1948 at 8:30 M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1948 to Nov. 28 1948
and that I last saw him 24 alive on November 28 1948Immediate cause of death pulmonary edema DURATION 12 hrsDue to essential hypertension 10 yrs

Due to

Other conditions decubitus ulcer 60 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

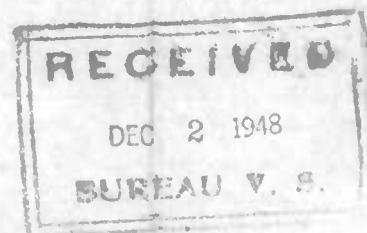
Means of injury Injured at work?

23. SIGNATURE St. C. Schaffenberg, M.D.
Wd. J. B. or otherAddress 4404 Sycamore Rd., Rockville Date signed 11-30-48

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11657

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's CountyCity or town Cheverly, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 hours

Hospital, institution, or street address where death occurred:

Prince George's General HospitalHow long in hospital or institution? 23 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince GeorgesCity or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 5701 - 40th
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HENRY Baby Boy De Vries

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

November 20, 1948 6. (c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) November 29, 19488. AGE: Years _____ Months _____ Days _____ If less than one day 23 hrs. _____ min.9. Birthplace CHEVERLY, PR. GEO. CO.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name John De Vries13. Birthplace New Jersey14. Maiden name Ditmar, MARIA15. Birthplace Michigan

16. Informant

Address

17. Cremation Date thereof 12/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prince George's General HospitalLocation Cheverly, Md.18. Funeral director P. J. Brady, SykesAddress Cheverly, Md.19. Dec 6 '48 Amanda A. Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1948 19_____, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19_____, to _____ 19_____,

and that I last saw him _____ alive on _____ 19_____,

Immediate cause of death _____ DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE _____ M. D. or other _____

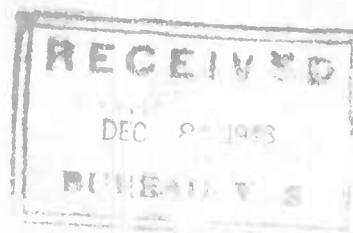
Address _____ Date signed 12-1-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11658 242

1. PLACE OF DEATH:

County Prince Georges

City or town Capital Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 years

Hospital, institution, or street address where death occurred:

6306- Brooks Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Capital Heights
(If outside city or town limits, write RURAL and give nearest town)Street No. 6306- Brooks Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Carrie Elizabeth Diggs

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George Diggs

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Oct. 20 - 1887.

8. AGE:

Years

Months

Days

It less than one day

61

1

8

hrs.

min.

9. Birthplace

Bradbury Ht. Ps. Geo. Comp.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

John Matthews

13. Birthplace

Annapolis Co. Md.

14. Maiden name

Lillie Berry

15. Birthplace

Pr. Georges Co. Md.

16. Informant

Katie Monroe

Address

524-56 St. N.E. Washington D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Dec. 2, 1948

Cemetery or crematory

Lincoln Cemetery

Location

Baltimore, Maryland

18. Funeral director

John J. Blair

Address

30 N. St. N.E. Wash. D.C.

19. Nov 29 1948

Carrie F. Campbell

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18 1948 to Nov. 28 1948

and that I last saw him alive on Nov. 28 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: It death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. C. Beal, M.D.

4223- Hunt Pl. N.E. Wash. D.C.

Date signed 11-29-48

RECEIVED

RECEIVED

RECEIVED

DEC 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

11659

1. PLACE OF DEATH:

County Prince Georges Co

City or town Mt Rainier Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? :

3. (a) FULL NAME

Martha Harding Slobyns

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Jennings L Slobyns

7. Birth date of deceased (mo., day, yr.) March 24, 1914.

6. (c) If alive, give age. years

8. AGE: Years 34 Months Days If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Emerson Otho Harding

13. Birthplace Va

14. Maiden name Martha Radmond

15. Birthplace Md

16. Informant Jennings L Slobyns

Address Mt. Rainier Md

17. Burial Date thereof Nov 19, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Melrose Cemetery

Location Melrose Va

18. Funeral director F Kascha sons

Address Hyattsville Md

19. Nov 17 1948

(Date rec'd by registrar) 48 James Sevey Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Georges

City or town Mt Rainier Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4215 Russell ave

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 November 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12 November 1948 to 17 November 1948

and that I last saw her alive on 16 November 1948

Immediate cause of death Generalized

CARCINOMATOSIS

DURATION

1-2 yr

Due to CARCINOMA UTERUS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Cheime

Address Berwyn, Md M. D. or other

Date signed 11-17-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11660

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Bladensburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr GeoCity or town Bladensburg, Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 5303 - Cinnapohio Rd -
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Earl Doney.

3. (b) Social Security Number

4. Sex M. 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Dorothy Lusia Doney7. Birth date of deceased (mo., day, yr.) Sept 2, 1959 6. (c) If alive, give age 59 years8. AGE: Years 5-9 Months 2 Days 5 If less than one day
.....hrs.min.9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation Mechanic

11. Industry or business

12. Name James Doney13. Birthplace Pennsylvania14. Maiden name Geneva Hovel15. Birthplace Pennsylvania16. Informant Francis C. DoneyAddress 5202 Cinnapohio Rd -17. Burial Date thereof Nov 10, 1948
(Burial, cremation, or removal. Which? (month) (day) (year))Cemetery or crematory Catholic CemeteryLocation Cunnsoutawney Pa18. Funeral director F. Gasch's SonsAddress Myattsville Md19. 11/8 48 Amanda Doney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 7 1948 at 7:00P A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Cardio-vascular renalDue to Atherosclerotic Coronarysclerosis - Sudden

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John W. Doney, Registrar Dep. MedicalAddress Cherry Hill, N.J. Date signed.....

RECEIVED

NOV 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11661

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's General

How long in hospital or institution? 8 days 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3819-58th Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Margaret Fierstein

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mr. Fierstein

7. Birth date of

deceased (mo., day, yr.)

Sept. 6, 1896

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

52

hrs. min.

9. Birthplace

Washington, D.C.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. For

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 November 19 48 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/8/48

19

to

11/17/48

19

and that I last saw him alive on

11/17/48

Immediate cause of death

Hemorrhage (Cerebral)

DURATION

1 week

Due to

Hypertension Heart Disease

10 years

Due to

Chronic Glomerulo-nephritis

Other conditions

Pulmonary Congestion
Bronchial Pneumonia

1 week

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results 1st hypertension, heart disease, chronic glomerulo-nephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albers-Ross, M.D.

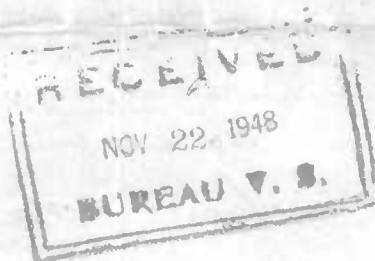
M. D. or other

Address 5435 Wisconsin Avenue Date signed 11/18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: Prince Georges
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since July 15, 1947
Hospital, institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? Since July 15, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2709, 36th Street
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

Mabel Coleman Fishback

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

8. (b) Name of husband or wife Frederick Lewis Fishback

7. Birth date of deceased (mo., day, yr.) July 17 1870 8. (c) If alive, give age - years

8. AGE: 78 Years 3 Months 17 Days If less than one day hrs. min.

9. Birthplace Michigan (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Philip Coleman

12. Name Philip Coleman

13. Birthplace Canada

14. Maiden name Sophie Wiltse

15. Birthplace Michigan

16. Informant Dr. J.C. Coggins B. F. C. Fishback

Address Laurel, Md. 1801 Eye St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4 1948

Cemetery or preparatory Rock Creek

Location Washington, D.C.

18. Funeral director Joseph Charles Lewis

Address 1756 Penna. Ave. N.W.

Nov 4 1948 M. Brashers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948 at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 17 1948 to Nov 4 1948 and that I last saw her alive on Nov 4 1948

Immediate cause of death Senile asthenia

Due to Senile arteriosclerosis

Other conditions Recent fall c hip fracture 8 days

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of Oct. 1948

Where did injury occur? Laurel, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fall Injured at work?

23. SIGNATURE J. C. Coggins

Address Laurel, Md. Date signed Nov 4, 1948

CERTIFICATE OF DEATH

RECEIVED

NOV 6 1948

BUREAU V. B.

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11663

Reg. Dist. No. 245

1. PLACE OF DEATH:

County PRINCE GEORGE'S
 City or town BRENTWOOD, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 YEARS
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County PRINCE GEO'S
 City or town BRENTWOOD
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3502 VARNUM ST
 (If rural, give LOCATION)
 2.(a) If veteran, name war NONE

3. (a) FULL NAME

Elizabeth VICTORIA FLYNN

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

CHARLES O FLYNNDECEASED

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

JULY 16 1882

8. AGE:

66

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

PHILADELPHIA PA.

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

NONE

12. Name

JOHN RHINEHARDT

13. Birthplace

GERMANY

14. Maiden name

NOT KNOWN

15. Birthplace

GERMANY

16. Informant

OGDEN V FLYNN

Address

3502 VARNUM ST BRENTWOOD MD17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

NOV 13 1948

(month) (day) (year)

Cemetery or crematory

CONGRESSIONAL

Location

WASHINGTON DC

18. Funeral director

W W Chambers Co

Address

3072 In St NW19. Nov 11

(Date rec'd by registrar)

19 48James Seery

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 19 48 at 1 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6 19 43, to Nov 11 19 48and that I last saw him alive on Nov 6 19 48

Immediate cause of death

Pul tbe.

DURATION

5 yr

Due to

Due to

Other conditions

-

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ed. Fenton

M. D. or other

Address

1835 Eye St NW

Date signed

Nov 11 48

RECEIVED

NOV 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11664

232

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

20

8

7

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

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(Date read by registrar)

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MEDICAL CERTIFICATION

A.N.I.

20. DATE OF DEATH

15 Nov

19.48

at

1235

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 Nov

19.48

to

15 Nov

19.48

and that I last saw him alive on

12 Nov

19.48

Immediate cause of death

Tuberculosis, latent, pulmonary

DURATION

1 year

Due to

Due to

Other conditions

Acute myocardial infarction, right ventricle, probably tuberculous

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert B. Casser

M. D.

Address

Upper Marlboro, Md

Date signed

15

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 224

1. PLACE OF DEATH:

County Prince GeorgeCity or town Accrue md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Prince GeorgeCity or town Accrue - 224
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Gordon

3. (b) Social Security Number

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 18708. AGE: Years 78 Months _____ Days _____

It less than one day _____ hrs. _____ min.

9. Birthplace Scotland

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name William Gordon13. Birthplace Scotland14. Maiden name Agnes Larsen15. Birthplace Scotland18. Informant Bruce GordonAddress Accrue md11. Burial Date thereof 11-30-48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. PeterLocation Bryans Road md18. Funeral director Hunt & RyanAddress Waldorf md19. Nov 18 19 48 M. P. Meyer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 19 48, at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 13 19 48, to Nov 17 19 48and that I last saw him alive on Nov 17 19 48

Immediate cause of death _____

DURATION

4 daysDue to Cerebral Vascular Accident

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Edwin P. Lane M.D.

M. D. or other

Address Waldorf md Date signed 4/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11665

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Pierce GayleCity or town Beverly Hills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State NY County NYCity or town 44 W 87th St.
(If outside city or town limits, write RURAL and give nearest town)Street No. 44 W 87th St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wilfred Leroy Guindorf

3. (b) Social Security Number

067-03-377

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

Elizabeth Guindorf

7. Birth date of deceased (mo., day, yr.)

June 13, 1886

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

62

hrs.

min.

9. Birthplace

Washington, DC.
(Town, county, and state)

10. Usual occupation

MANAGER - RESTAURANT

11. Industry or business

MOTHER FATHER

12. Name

Wilfred Guindorf

13. Birthplace

CANADA

14. Maiden name

JENNIE MAGILL

15. Birthplace

MICHIGAN
Elizabeth Guindorf

16. Informant

Address

Transportation Nov 25, 1948

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Oyster Bay

Location

L.I.C. New York

18. Funeral director

L. Gascho sons

Address

Hyattsville Md

19.

(Date rec'd by registrar)

Nov 25, 1948 Amanda Dorozy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-2419 48 at 5 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-12-19 48 to 11-24 19 48

and that I last saw him alive on

11-23 19 48

Immediate cause of death

Coronary of
Levif

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Alfred B. Leaf

M. D. or other

Address

175 E. 11th St.Date signed 11-24-48

RECEIVED

NOV 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11667

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Oaklawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:

7351 Allentown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Prince Georges

City or town Oaklawn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7351 - Allentown Road

(If rural, give LOCATION)

2. (a) If veteran, name war World War I

3. (a) FULL NAME

Lewis Franklin Hanbury, Sr

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Audrey Hanbury

6. (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) March 30, 1892

8. AGE: Years 56 Months Days If less than one day hrs. min.

9. Birthplace Virginia

(town, county, and state)

10. Usual occupation machinist

11. Industry or business Iron Works

12. Name Forestall Hanbury

13. Birthplace Virginia

14. Maiden name Ada Taylor

15. Birthplace Virginia

16. Informant Audrey Griffin Hanbury

Address 7351 - Allentown Rd

17. BURIAL Date thereof Nov 13 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Maryland

18. Funeral director Chas. Chambers

Address 517 11th Street S.E. Wash.

19. Nov. 11 1948 Carrie F. Campbell

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948 at 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Acute congestive heart failure

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Keegan Medical Examiner

23. SIGNATURE

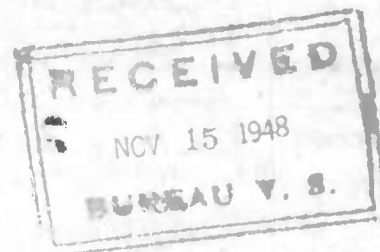
Forestall Rd Date signed 11-10-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11668
231

1. PLACE OF DEATH:

County Prince George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days 11 hrs 24 min
Hospital, institution, or street address where death occurred:
Prince George Hospital
How long in hospital or institution? 29 days 11 hrs 24 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Washington
City or town Bellevue
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1603 Benlworth Ave
(If rural, give LOCATION)
(a) If veteran, name war

3. (a) FULL NAME

Heinlein, Mr. Edward

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 13, 1902 6. (c) If alive, give age years

8. AGE: Years 46 Months 4 Days 9 If less than one day hrs. min.

9. Birthplace Mass
(Town, county, and state)

10. Usual occupation milkman

11. Industry or business

12. Name William E Heinlein

13. Birthplace Mass

14. Maiden name Josephine Geigler

15. Birthplace Mass

16. Informant SON Aiden Heinlein

Address 1603 Kennilworth Ave. N.E.

17. removal Date thereof 11/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory removal

Location Washington D.C.

18. Funeral director Timothy Houlton

Address 641 N. ST. N.E.

19. For 4 19 48 Amanda Woodard
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 19 48 at 7:27 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 19 48 to Nov. 4 19 48
and that I last saw him alive on NOVEMBER 3 19 48

Immediate cause of death Carcinoma of urethra DURATION ?

Due to Cachexia ?

Due to Carcinoma of urethra

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Squamous cell Carcinoma of urethra - surrounding tissue. 7.27.48

Autopsy results Autopsy permission refused

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE D. S. Blayman, M.D. M. D. or other

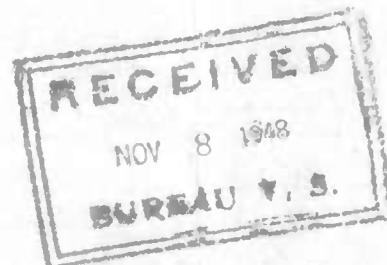
Address 641 N. ST. N.E. Date signed 11-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11669

Reg. Dist. No. *131a* *net*

1. PLACE OF DEATH:

County *Prince Georges*
 City or town *Hyattsville Md*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *44 years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For whom infants give residence of mother)
 State *Md* County *Prince Georges*
 City or town *Hyattsville Md*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *4230 Ogletree St*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edward Jerome Kierling, sr

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *Married*
 6.(b) Name of husband or wife *Mae K. Kierling*
 7. Birth date of deceased (mo., day, yr.) *July 10, 1888* 6.(c) If alive, give age *56* years
 8. AGE: Years *60* Months Days If less than one day hrs. min.

9. Birthplace *Washington D.C.*
 (Town, county, and state)
 10. Usual occupation *salesman*
 11. Industry or business *Gunn & Co*
 12. Name *Edward Kierling*
 13. Birthplace *Germany*
 14. Maiden name *Mida Allen*
 15. Birthplace *Rockville Md*

16. Informant *Mae Mae K. Kierling*
 Address *Hyattsville Md*
 17. *Burial* Date thereof *Nov 18, 1948*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory *Congressional*
 Location *Washington D.C.*
 18. Funeral director *F. Guiche, sons*
 Address *Hyattsville Md*
 19. *Nov 17 1948* *James Sevey*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 16* 19 *48* at *1:30 AM*
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July* 19 *48* to *Nov. 16* 19 *48*
 and that I last saw him alive on *November 15* 19 *48*
 Immediate cause of death *Acute congestive heart failure* DURATION *7 days*
 Due to *Hypertensive Heart Disease* years
 Due to *Arteriosclerotic cardio-vascular renal disease* years
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE *Ronald J. Fleischer, M.D.*
 Address *5401-31st Ave. Hyattsville* Date signed *11-16-48*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11670 245
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George's CountyCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yearsHospital, institution, or street address where death occurred:
4407 41st StreetHow long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)Street No. 4407 41st Street
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

CLIFTON MERDITH HODGSON

3. (b) Social Security Number

577-03-9890

4. Sex <u>MALE</u>	5. Color or race <u>WHITE</u>	6. (a) Single, married, widowed, or divorced <u>WIDOWED</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Anna Lee Hodgson
(deceased) 6. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) November 3, 1874

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>0</u>	<u>18</u>hrs.min.

9. Birthplace Winchester, Virginia
(Town, county, and state)10. Usual occupation Night Manager11. Industry or business Willard Hotel, Wash., D.C.12. Name Edward Luther Hodgson13. Birthplace Winchester, Virginia14. Maiden name Isabelle Woodward15. Birthplace Unknown16. Informant Mr. C. Fitzhugh Hodgson - SonAddress 4407 41st St., Brentwood, Md.17. BURIAL Date thereof Nov. 24, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery MT. HebronLocation Winchester, Va.18. Funeral director W. W. CHAMBERS COMPANYAddress 5801 Cleveland Ave., Riverdale, Md.19. Nov 22 1948 J. Lewis Seay
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1948 at 12:10 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6-7 1946, to 11/21 1948and that I last saw him alive on 11/21 1948Immediate cause of death Hypertensive
cardio-vascular disease
Congestive heart failure DURATION 1 week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury injured at work?

23. SIGNATURE George H. Hargrave M. D. or otherAddress 3117 38th Ave Date signed 11/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 24 1948

BUREAU V. S.

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11671

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince George's
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years
 Hospital, institution, or street address where death occurred:

Old Boltz Inn Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr. George's
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Old Boltz Inn Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

(SALLIE) Sally Rosalie Hefbrino

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife William Alexander

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1878

8. AGE: Years 69 Months 11 Days 8 If less than one day
 hrs. min.

9. Birthplace Fairfax Virginia
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Self12. Name CHARLES MANDRELL13. Birthplace Virginia14. Maiden name SARAH STONE15. Birthplace Virginia16. Informant Mrs. Julia A. LeeAddress Boltzville, Maryland17. Burial Burial Date thereof Nov. 29, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Church Cemetery, Jerusalem Baptist Church, Fairfax Station, VirginiaLocation Fairfax Station, Virginia18. Funeral director Chas. E. Chambers & CoAddress 5801 Cleveland Ave, Riverdale Md19. Nov 27 1948 James Severy

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1948 at 6:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 13 1947 to November 26 1948
 and that I last saw him alive on November 26 1948

Immediate cause of death Sphygmia of brain
 Due to arterio sclerosis
 Due to Age

Other conditions None
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. HefbrinoAddress 402 Main St. Laurel MdDate signed 11/26/48

RECEIVED

DEC 1 1948

BUREAU V. S.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County **Prince Georges**
 City or town **Andrews Air Force Base**
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:
Andrews Air Force Base

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State **Maryland** County **Beth**
 City or town **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **10 Ridge Rd.**
 (If rural, give LOCATION)

2.(a) If veteran, name war ☒

3. (a) FULL NAME

JAMES, BERNARD M.

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Single**

6.(b) Name of husband or wife
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **August 8, 1923**
 8. AGE: Years **25** Months **3** Days **16** If less than one day hrs. min.

9. Birthplace **Baltimore Maryland**
 (Town, county, and state)

10. Usual occupation **Officer U.S. Air Force**

11. Industry or business

12. Name **Arthur V. L. James**
 13. Birthplace **Maryland**

14. Maiden name **Ellen M. Moran**
 15. Birthplace **Baltimore Md.**

16. Informant **Arthur V. L. James**
 Address **10 Ridge Rd. Catonsville Md.**

17. Burial Date thereof **Nov. 29, 1948**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **New Cathedral Cem.**

Location **Baltimore Md.**
Wastler Funeral Home Inc.
 18. Funeral director **Wastler Funeral Home Inc.**

Address **301 E. Capitol St. Washington D.C.**

19. (Date rec'd by registrar) **19** Registrar

MEDICAL CERTIFICATION

Approx

20. DATE OF DEATH **24 November** 19 **48** at **2359** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19
 Immediate cause of death **Multiple crushing injuries generalized entire body with destruction of vital organs.**

Due to **AI while on duty when C-45 Aircraft crashed.**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of **Andrews AFB, Prince Georges, Md**
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury **Aircraft Accident** Injured at work? **Yes**

Francis E. Barry
FRANCIS E. BARRY, Captain, MC

23. SIGNATURE **Francis E. Barry**
 M. D. or other

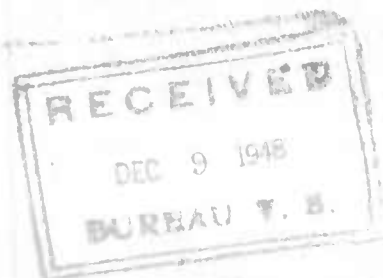
Address Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11673

Reg. Dist. No. 248

1. PLACE OF DEATH:

County Prince George
 City or town Riverdale, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days and half day
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 days and one half day

3. (a) FULL NAME

Baby Girl Jones, CAROL ANN

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov 14 1948

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

3 1/2 days3

..... hrs. min.

9. Birthplace Riverdale, Pr. Geor. Co., Maryland.

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

12. Name Mr. Charles H. Jones.13. Birthplace Washington, D.C.14. Maiden name Mrs. Laura ~~Thomas~~ Jones15. Birthplace Washington, D.C.16. Informant Leland Memorial HospitalAddress Riverdale, Md.17. Burial Date thereof Nov 20, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EvergreenLocation Bladensburg Md18. Funeral director F. Paschke, sonAddress Hyattsville Md.19. Nov 20 1948 James Searcy

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED: Infant

(For newborn infants give residence of mother)

State Md County Prince GeoCity or town Riverdale Md - 42.5 St
 (If outside city or town limits, write RURAL and give nearest town)Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 14 1948 to Nov 17 1948and that I last saw him/her alive on November 17 1948Immediate cause of death asphyxiation

DURATION

Due to aspiration of vomitus Sudden

Due to

Other conditions Prematurity

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

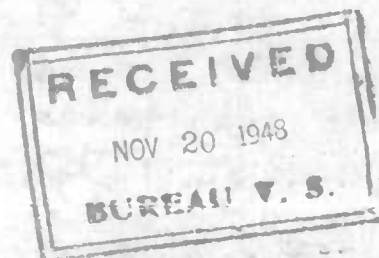
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Scharffenberg M.D.

M. D. or other

Address 4404 Queensbury Rd. Riverdale Md Date signed 11-17-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11674

Reg. Dist. No. 230

1. PLACE OF DEATH:

County PRINCE GEORGECity or town BELTSVILLE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 YRS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince GeorgeCity or town BELTSVILLE
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2. (a) If veteran, name war NONE

3. (a) FULL NAME

Robert P. Jones

3. (b) Social Security Number

579-01-66104. Sex MALE5. Color or race WHITE6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife EDNA M. JONES

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) APRIL 4TH, 18928. AGE: Years 56 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace CALAHAN, FLORIDA
(Town, county, and state)10. Usual occupation TELEGRAPH OPERATOR11. Industry or business WESTERN UNION12. Name JOHN FRANKLIN JONES13. Birthplace FLORIDA14. Maiden name MARGARET BURNS O'GLOY15. Birthplace FLORIDA16. Informant EDNA M. JONESAddress BELTSVILLE, MD17. BURIAL Date thereof Nov. 30TH 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory JONES FAMILY CEMETERYLocation CALAHAN, FLORIDA18. Funeral director W. W. CHANDERS Co.Address 5701 CLEVELAND AVE - RIVERDALE, MD.19. Nov 27 48 James Sever
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948 at 2:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1948, to November 26 1948.and that I last saw him alive on Nov 26 1948.Immediate cause of death Cirrhosis LiverDURATION 6 mosDue to Chronic Alcoholism

Due to _____

Other conditions Chronic Bronchitis& Emphysema

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. W. Sever MDAddress Laurel Date signed 11/27/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11675

Reg. Dist. No. 245

1. PLACE OF DEATH: 6119 42nd Place, Mt. Rainier
 County..... Prince Georges County
 City or town..... Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Since May 8, 1948
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland..... County..... Prince Georges.....
 City or town..... Hyattsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 6119 42nd Place
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MRS. ORPHA JUDY

(ORPHA JERREL JUDY)

3. (b) Social Security Number

4. Sex..... Female
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Widowed
 8. AGE: Years..... 50 Months..... 3 Days..... 8 If less than one day..... hrs. min.
 9. Birthplace..... Flinstone, Maryland
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....

12. Name..... David Furlow
 13. Birthplace..... Cumberland, Maryland
 14. Maiden name..... Mary Gordon
 15. Birthplace..... Flinstone, Maryland

16. Informant..... Miss Nellie Judy
 Address..... 6119-42nd Pl., Hyattsville, Md.

17. Removal..... Date thereof..... December 1/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Everett,
 Location..... Everett, Pennsylvania

18. Funeral director..... Martin W. Hyson Co.
 Address..... 1300-N Street N.W., Washington, D.C.

19. Dec 1 1948 James Sevier Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 30th, 1948, at 11:50P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1947 to Nov 30 1948 and that I last saw him alive on Nov 30 1948

Immediate cause of death..... Coronary occlusion 4 hours
 arterio sclerosis & Hypertension 4 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert B. Bacon, M.D.
 Suite 107 Burlington Hotel M. D. or other
 Address..... Date signed..... 12/1/48

RECEIVED

DEC 2 1948

BUREAU V. S.

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11676

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges
 City or town Cherry
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 1/2 hrs
 Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
 How long in hospital or institution? 6 1/2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Sandover
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war No.

3. (a) FULL NAME

Helmuth Herbert Kuenne
 4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

3. (b) Social Security Number

None.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1948, at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him alive on _____ 19____

Immediate cause of death Massive laceration & contusion of brain. DURATION _____

Due to Compound fracture parieto-occipital avulsion

Due to kick of horse

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-25-48

Where did injury occur? Sandover Pr. Geo. Maryland
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury kick by horse Injured at work? _____

23. SIGNATURE John D. Maloney, Medical Examiner
 M. D. or other _____
 Address Cherry-Hyattsville Date signed 11-26-48

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 14, 1898

8. AGE: Years 50 Months 8 Days 12 It less than one day _____ hrs. _____ min.

9. Birthplace Taylor County, Wisconsin
 (Town, county, and state)
Farmer.

10. Usual occupation _____

11. Industry or business _____

12. Name Valdemar Kuenne

13. Birthplace Germany

14. Maiden name Bertha Margenag

15. Birthplace Switzerland

16. Informant Raymond Kuenner, Bro.

Address Sandover, Maryland

17. Burial Date thereof Nov. 29, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forestville Epiphany

Location Forestville, Md.

18. Funeral director Ridchie Bros.

Address Upper Marlboro, Md.

19. 11/26 1948 Amanda Downey
 (Date rec'd by registrar) Registrar

RECEIVED

NOV 29 1948

BUREAU V. S.

Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11677

FILM NO. G 118 DEC 14 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, institution, or street address where death occurred:
4010 - Longfellow Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4010 - Longfellow
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Leigh Joseph Maisei

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Frances Maisei

7. Birth date of deceased (mo., day, yr.) May 27, 1888

8. AGE: Years 66 Months 5 Days 27 It less than one day hrs. min.

9. Birthplace Patonsville, Md.
(Town, county, and state)

10. Usual occupation Inspector

11. Industry or business Wash. Sub. San. Comm.

12. Name Nicholas J. Maisei

13. Birthplace Unknown

14. Maiden name Elizabeth Koeler

15. Birthplace Unknown

16. Informant Mrs. Ruth Maisei

Address 4010 - Longfellow Street

17. Burial Date thereof Nov 26, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Washington D.C.

18. Funeral director F. Gleck's sons

Address Hyattsville Md.

Nov 26 1948 James Severs

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 6:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

Coronary Occlusion

Due to Cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature John W. Maloney Deputy

Cherry-Hyattsville Md. 11-24-48

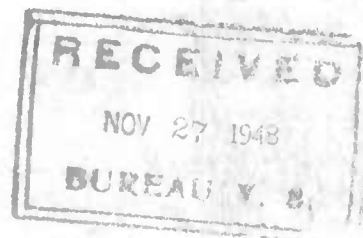
Address Date signed

MARGIN RESERVED FOR BINDING

I

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11678 242

1. PLACE OF DEATH:

County Prince GeorgeCity or town Bradley Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Prince GeorgeCity or town Bradley Heights
(If outside city or town limits, write RURAL and give nearest town)Street No. 4813 R.H.S.E.
(If rural, give LOCATION)2.(a) If veteran, name war ve

3. (a) FULL NAME

George Edward Martin

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Leanne R. Hawcett Martin8. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) May 28 18848. AGE: Years 62 Months Days If less than one day
hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Retired Wash Navy Yard

11. Industry or business

12. Name Philip Martin13. Birthplace Germany14. Maiden name Laura H. Hoombs15. Birthplace Maryland16. Informant Leanne R. Hawcett MartinAddress 4813 R.H.S.E.17. Burial Date thereof 11-12-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Prince George Inst. Md.18. Funeral director Rev. W. H. H. 388Address 4601-5th St. N.W.19. Nov 10 19 48 Gavin F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 9 19 48 at 9:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 19 48 to November 9 19 48and that I last saw him alive on November 8 19 48

Immediate cause of death

CORONARY heart disease

DURATION

3 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gavin F. Campbell M.D.

M. D. or other

Address 4409 3rd St. N.E. Wash DC Date signed Nov 9 1948

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

RECEIVED

1948

RECEIVED

NOV 15 1948.

BUREAU V. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11679

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince George's County
 City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 days
 Hospital, institution, or street address where death occurred:
Martha Jones Rest Home
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Prince Geo.
 City or town Chillum
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Ray Road.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MARTHA C. McDONALD

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Charles E. McDonald
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Sept. 21 1879
 8. AGE: Years 69 Months 2 Days 1 If less than one day..... hrs. min.

9. Birthplace Housewife Montgomery Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Same
 12. Name Robert H. Norton
 13. Birthplace Montgomery Co. Md.
 14. Maiden name Esther Goodman
 15. Birthplace Maryland

16. Informant Charles E. McDonald
 Address Ray Road, Chillum, Md.
 17. Burial Date thereof Nov. 24, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rock Creek Cemetery
 Location Rock Creek Ch. Rd. & Webster St. NW
 18. Funeral director J. Arthur Walter
 Address 254 Canale St NW, Tak Park D.C.
 19. November 22nd 48 John D. Samuels
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 19 48 at 1:25 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Oct 19 48, to 11-19 19 48,
 and that I last saw her alive on 19 Nov 19 48.

Immediate cause of death Hypertensive Heart Disease DURATION 1 1/2 yrs

Due to.....
 Due to.....
 Other conditions gangrene of the toes.
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury Injured at work?

23. SIGNATURE Ernesta. Sarno M.D. M. D. or other
6711 New Hampshire Ave Address Date signed 22 Nov 48

RECEIVED

NOV 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11680

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George's

City or town Connelly Hills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

517-73rd Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Connelly Hills
(If outside city or town limits, write RURAL and give nearest town)Street No. 517-73rd Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John Meier

3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife Mary Ann Meier

7. Birth date of deceased (mo., day, yr.)

July 20, 1861

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

87

hrs.

min.

8. Birthplace

Switzerland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Switzerland

14. Maiden name

Unknown

15. Birthplace

Switzerland

16. Informant

Alfred Meier

Address

517-73rd St, Connelly Hills Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov 5, 48

(month) (day) (year)

Cemetery or crematory

Location

Washington D.C.

18. Funeral director

Address

W.W. Chambers Co

517-11 St S.E.

19.

(Date rec'd by registrar)

19 48

Carrie F. Campbell

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 19 48 at 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h... alive on 19

Immediate cause of death

acute congestive

heart failure

cardiovascular renal

disease

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

1-5-48

MARGIN RESERVED FOR BINDING

9-45-53M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11681

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges
City or town Cheverly, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 hours
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 32 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County Pr. Geo.
City or town BERWYN
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5005 EUTAW PL.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Meredith

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced New-born
6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) November 16, 1948 6.(c) If alive, give age 14 years
8. AGE: Years Months Days If less than one day
14 0 1 8 hrs. 1 min.

9. Birthplace Prince Georges General Hospital
(Town, county, and state)
10. Usual occupation New born
11. Industry or business
12. Name Marian W. Meredith
13. Birthplace TALEWELL, V.A.
14. Maiden name Elinor Inscot
15. Birthplace WASH. D.C.

16. Informant Mother -
Address 5005 Eutan H- Berwyn. Md
17. Cremation Date thereof 11/19/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Prince Georges General Hospital
Location Cheverly, Md.
18. Funeral director G. H. Bealy, Supt.
Address Cheverly, Md.
19. Nov 22 19 48 Amanda Dorey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

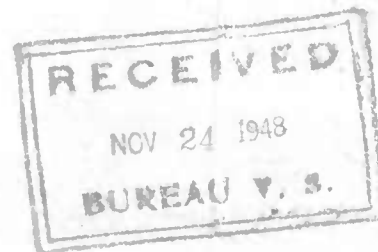
20. DATE OF DEATH 17 November 19 48, at 9:15 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16 19 48 to Nov 17 19 48
and that I last saw him alive on 10/17 19 48
Immediate cause of death Pneumonia
DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE J. A. [Signature] M. D. or other
Address College Park, Md. Date signed 10/17/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 93d

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges Co
 City or town Hyattsville Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Not in home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Va County Jefferson
 City or town Charlottesville Va
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth

3. (b) Social Security Number

Moore

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Theodore Moore
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 20 1870
 8. AGE: Years 78 Months 0 Days ✓ If less than one day _____ hrs. _____ min.

9. Birthplace New York
(Town, county, and state)10. Usual occupation Home mfr

11. Industry or business _____

FATHER 12. Name Benjamin Meyers13. Birthplace New YorkMOTHER 14. Maiden name Elizabeth Patton15. Birthplace New York16. Informant Margaret D MooreAddress Charlottesville Va17. Burial Nov 25 1948
(Burial, cremation, or removal) Which? _____ Date thereof _____ (month) (day) (year)Cemetery or crematory CharlestonLocation West Va18. Funeral director F Gaschi songAddress Hyattsville Md19. Nov 25 48 James Elexy
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1948 at 7 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7 1948 to Nov 22 1948
 and that I last saw him alive on Nov 22 1948

Immediate cause of death

Right Stenoplegia

DURATION

2 1/2 yrsDue to Cardiovascular Disease
Gen Arteriosclerosis & Hypertension

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Howard T. Jones M.D.28 Carroll Ave M. D. or other _____Address Tahoma Park, Md Date signed 11/23/48

RECEIVED

NOV 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11683

Reg. Dist. No. 22/5

1. PLACE OF DEATH:

County PR. GEO. CO.City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 MOS.

Hospital, institution, or street address where death occurred:

SURED HEART HOMEHow long in hospital or institution? 26 MOS.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERYCity or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)Street No. 9317 COLEVILLE ROAD
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Sallie W Mudd

3.(b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOW6.(b) Name of husband or wife Thomas N.7. Birth date of deceased (mo., day, yr.) Oct. 8, 18598.(c) If alive, give age - years

8. AGE:

Years

Months

Days

It less than one day

89120

hrs.

min.

9. Birthplace PR. GEO. CO. MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

MOTHER FATHER

12. Name THOMAS O. WILSON13. Birthplace MONT. CO., MARYLAND14. Maiden name SARAH BONIFANT15. Birthplace MONT. CO., MARYLAND19. Informant THOMAS N. MUDD, JR.Address 9317 - COLEVILLE ROAD17. BURIAL Date thereof DEC. 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HOLY ROSARY CEMETERYLocation ROSNAYVILLE, MARYLAND18. Funeral director Jenny P. Ryan, Inc.Address 311 Penna. Ave., S.E.19. Nov 29 1948 Jenny P. Ryan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1948 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1948 to Nov 28 1948
and that I last saw him alive on Nov 27 1948

Immediate cause of death

Coronary artery
infarction

DURATION

1 year

Due to

Due to

Other conditions

Coronary artery
infarction

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Ryan, Jr.
M. D. or otherAddress 35 W. Ave. W. Date signed Nov 28 1948

CERTIFICATE OF DEATH

RECEIVED

DEC 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

11684

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
City or town Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

he Land Memorial HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Jessup
(If outside city or town limits, write RURAL and give nearest town)Street No. Jessup Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edith Mullins

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Quincy Mullins7. Birth date of
deceased (mo., day, yr.)February, 19216.(c) If alive, give age 30 years

8. AGE:

Years

Months

Days

If less than one day

279

hrs.

min.

9. Birthplace

Sneidsville, Hancock, Tenn.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

none

MOTHER FATHER

12. Name

Emory Johnson

13. Birthplace

Sneidsville, Hancock, Tenn.

14. Maiden name

Maudie Johnson

15. Birthplace

Sneidsville, Hancock, Tenn.

16. Informant

Emory Johnson

Address

Jessup, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 4 1948
(month) (day) (year)

Cemetery or crematory

Lincoln Chapel

Location

Clarkeville, Howard Co

18. Funeral director

Ridgely Selby

Address

401 Wash. Ave. Laurel Md

19.

Dec 3

1948

James Seery

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 NOVEMBER 1948 at 11 39 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

27 NOVEMBER 1948 to 30 NOVEMBER 1948and that I last saw him alive on 30 NOVEMBER 1948

Immediate cause of death

POST PARTUM HEMORRHAGE 2 HRS

DURATION

Due to

Due to

Other conditions

PREGNANCY7 1/2 mos

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

None PERFORMED

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thomas R. Whitfield MD

M.D. or other

Address 322 Prince George StDate signed 30 Nov 48

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

DEC 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11685

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 11 mos., 10 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 11 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 513 M. St., N. W., Apt. #3
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

SARAH NEAL

3. (b) Social Security Number

- - -

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Negro	Single

6. (b) Name of husband or wife..... - - -

7. Birth date of deceased (mo., day, yr.) June 26, 1924
 6. (c) If alive, give age..... years

8. AGE:	Years	Months	Days	If less than one day
24	24	4	18	hrs. min.

9. Birthplace..... Leonardtown, Maryland
 (Town, county, and state)
 Clerk

10. Usual occupation.....

11. Industry or business..... - - -

12. Name..... Leonard Neal

13. Birthplace..... Leonardtown, Maryland

14. Maiden name..... Gertrude Barnes

15. Birthplace..... Leonardtown, Maryland

16. Informant..... Deceased

Address.....

17. removal Date thereof Nov 13 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Leonardtown, Md.

18. Funeral director..... W. C. Mattingley, Sars

Address..... Leonardtown, Md.

19. Nov 13 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 13 1948 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2, 1946 to Nov. 13 1948
 and that I last saw her alive on Nov. 12, 1948

Immediate cause of death
 Pulmonary Tuberculosis DURATION 2 yr. 3 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

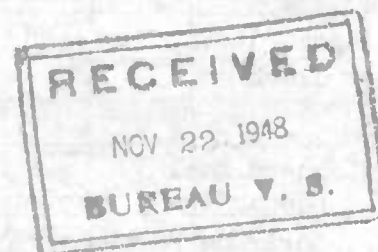
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Daniel Leo Pinckard MD

M. D. or other

Address..... Glenn Dale, Md. Date signed 11/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11686

Reg. Diat. No. 231

1. PLACE OF DEATH:

County Prince George
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 hrs. 35 min.
 Hospital, institution, or street address where death occurred:
Prince George General
 How long in hospital or institution? 16 hrs. 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Pr. George
 City or town University Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4418 Underwood St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Newman, Tillie R

3. (b) Social Security Number

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 1, 1894 6.(c) If alive, give age..... years

8. AGE: Years 74 Months 5 Days If less than one day hrs. min.

9. Birthplace Pennsylvania
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Benjamin Roat
 13. Birthplace Pa
 14. Maiden name Tillie Roat
 15. Birthplace Pa

16. Informant Benjamin E. Anderson, son
 Address 4418 Underwood St. University Park, Md

17. suicide Date thereof 11-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wash. Natl. Cemetery
 Location Suit land. and

18. Funeral director Wm O. Chambers &
 Address Gravesdale. Md

19. Nov 3rd 1948 Amanda Lowrey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 11-2 1948 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-15 1948 to 11-2 1948
 and that I last saw him alive on 11-1 1948

Immediate cause of death..... DURATION
Extensive Thrombophlebitis

Due to of Rt. Leg.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE W. D. W. D.
 M. D. or other
 Address Hotelle, Va Date signed 11-2-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

11687

93d

1. PLACE OF DEATH:

County Prince George's
 City or town Suitland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 days
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince George's
 City or town Suitland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5501 Silver Hill Rd
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

MATT. RANSOM. NEWSON.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Salv B Newson7. Birth date of deceased (mo., day, yr.) Apr. 28, 1870 6. (c) If alive, give age 78 years8. AGE: Years 78 Months 7 Days 6 If less than one day hrs. min.9. Birthplace MD Bay (Town, county, and state)10. Usual occupation Farmer11. Industry or business Farmer12. Name Ferry Newson13. Birthplace MD Bay14. Maiden name Rennie Nicholson15. Birthplace MD Bay16. Informant Mittie HudsonAddress 5501 Silver Hill Rd17. Date of death Nov 22, 194818. Funeral director Chamber'sAddress 517-11 St SE19. Date rec'd by registrar Nov. 23, 1948 Registrar Carrie F. Campbell

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22, 1948 at 8:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11, 1948 to Nov. 19, 1948 and that I last saw him alive on Nov. 19, 1948Immediate cause of death Acute Cardiac Failure DURATION one monthDue to Chronic Myocarditis & valvular disease. UnknownDue to Chronic Myocarditis & valvular disease. Several years?Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE May E. Friedman MD M. D. or otherAddress 3800 S. Capital St. Date signed 11/23/48

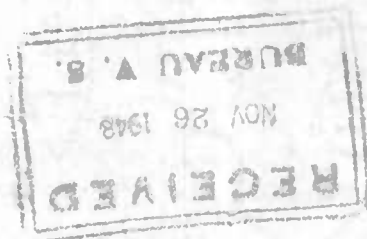
MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

I am Licensed in D.C.

Also licensed in Md. Dec. 27, 1933, but have not
registered in Md. Coroner Notified + OK'd death
certificate Max E. Feldman Md. 11/23/48.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

Reg. Dist. No. 11688 231

1. PLACE OF DEATH:

County Pr. George
City or town Near Sandown Hills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transit
Hospital, institution, or street address where death occurred:
Defense Highway & Andrews Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Pr. Geo
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1661 - Woodale St N.E.
(If rural, give LOCATION)
2. (a) If veteran, name war ☒

3. (a) FULL NAME

Annie Oliver

3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6. (a) Single, married, widowed, or divorced separated
6. (b) Name of husband or wife sender Oliver
7. Birth date of deceased (mo., day, yr.) Dec 25, 1923 6. (c) If alive, give age 26 years

8. AGE: Years 34 Months Days If less than one day hrs. min.

9. Birthplace wedgefield south Carolina
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER
12. Name Louis Brown
13. Birthplace wedgefield south Carolina
14. Maiden name Rachel Brown
15. Birthplace wedgefield south Carolina

16. Informant Lilly May Oliver

Address 1000 M st N.W. Washington D.C.

17. Removal Removal Date thereof Nov 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smith Funeral Home
1125 - 19 st N.W. Washington D.C.

18. Funeral director F. Rosetti sons

Address Hyattsville Md.

19. Nov 28 48 Amanda Horney Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25, 48 at 10:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Fracture - dislocation of
4th cervical vertebra
Due to Automobile accident
Due to

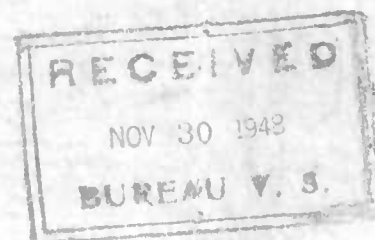
Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 11-25-48

Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Highway
Means of injury Auto accident Injured at work? No

23. SIGNATURE John D. Maloney, M.D. Cheryl Hyattsville
M. D. or other
Date signed 11-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11689

Reg. Diat. No. 214

1. PLACE OF DEATH:

County Prince Geo CountyCity or town Lakona Pk. Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 34 days

3. (a) FULL NAME

Sarah Janie Perkins

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

E

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Sept 12, 1880

8. AGE:

Years

Months

Days

If less than one day

68

hrs. min.

9. Birthplace

E.
(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Josephine Schaeffer
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/5

19

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 3

19

to

19

and that I last saw him

alive on

19

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

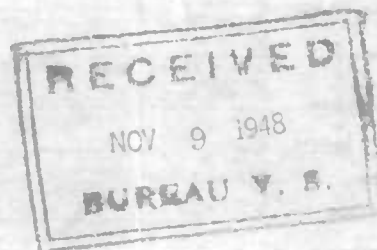
Injured at work?

23. SIGNATURE

Address

Date signed

Co. 432
at 6700



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11691

Reg. Dist. No. 245

1. PLACE OF DEATH:

County PRINCE GEORGE COUNTYCity or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Ten Minutes

Hospital, institution, or street address where death occurred:

5802 Baltimore AvenueHow long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGECity or town Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. 5801 CLEVELAND AVENUE
(If rural, give LOCATION)2.(a) If veteran, name war NONE

3. (a) FULL NAME

ORBY O PHILLIPS

3. (b) Social Security Number

578-10-1441

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife MARY COOPER PHILLIPS

7. Birth date of

deceased (mo., day, yr.)

June 20, 18946. (c) If alive, give age 58 years

8. AGE:

Years

Months

Days

If less than one day

5456

hrs.

min.

9. Birthplace

Hinton, West Virginia
(Town, county, and state)10. Usual occupation FUNERAL DIRECTOR AND EMBALMER11. Industry or business W.W. CHAMBERS CO. Riverdale, Md.FATHER
MOTHER

12. Name

Joseph Phillips

13. Birthplace

Virginia

14. Maiden name

Cora Meadows

15. Birthplace

Hinton, West Virginia

16. Informant

Mrs. Mary Cooper PhillipsAddress 5801 Cleveland Ave, Riverdale, Md.

17.

BURIAL

Date thereof

Nov 18, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

ROCK CREEK CEMETERY

Location

WASHINGTON D.C.

18. Funeral director

W.W. Chambers CoAddress 5801 Cleveland Ave, Riverdale, Md.

19.

Nov 16
(Date rec'd by registrar)

19

4F James Henry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1948, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to 19

and that I last saw him alive on 19

Immediate cause of death

Acute cardiac dilatation
Coronary-vascular renal
disease.

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Maloney, Deputy Med. Examiner
Chesley Hyattsville, Md.

M. D. other

Date signed Nov 16, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 18 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **331**

11690

1956

1. PLACE OF DEATH:

County **Prince George's**

City or town **Cheverly**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **63 days, 8 hours, 15 min.**

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? **63 days, 8 hours, 15 mins.**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Howard**

City or town **Laurel**
(If outside city or town limits, write RURAL and give nearest town)

Street No. **R.F.D. 1**
(If rural, give LOCATION)

2.(a) If veteran, name war ☒

3. (a) FULL NAME

Joan Pindell
Jacqueline Pindell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **9-4-48**

6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day
2 1 hrs. min.

9. Birthplace **Cheverly, Prince George's, Md.**
(Town, county, and state)

10. Usual occupation **none**

11. Industry or business

FATHER 12. Name **DOUGLAS B. PINDELL**
13. Birthplace **FULTON, Md.**

MOTHER 14. Maiden name **SHIRLEY MILLER**
15. Birthplace **BALTIMORE, Md.**

16. Informant **Douglas B. Pindell**
Address **R.F.D. #1, Laurel, Md.**

17. **Burial** Date thereof **Nov. 6, 1956**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **ST. MARKS CEMETERY**
HIGHLAND, Md.

18. Funeral director **John H. Hattis Funeral Home**
Address **505 Washington Blvd., Laurel, Md.**

19. **For 6** 19 **56** **Cemanda Kowarsky**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **November 6, 1956** at **10:30 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death

Bilateral tubercles

Contributory: anasthetic shock

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **John J. Maloney** **Sup. Medical**
Cherly Hyatt M. D. or other

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 9 1948
BUREAU V. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11692

Reg. Dist. No. *245*

1. PLACE OF DEATH:

County *Prince George*
 City or town *Riverdale, Md. - Rural*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *13 days*
 Hospital, institution, or street address where death occurred:
Island Memorial Hosp.
 How long in hospital or institution? *13 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Prince Georges*
 City or town *Ritchie, Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *7122 Ritchie Rd.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Anna Selma Puraschintz

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife *Henry Puraschintz*

7. Birth date of deceased (mo., day, yr.) *April 3rd 1887* 8.(c) If alive, give age *72* years

8. AGE: Years *61* Months *7* Days *7* If less than one day
hrs.min.

9. Birthplace *Medford, Wis.*
 (Town, county, and state)

10. Usual occupation *Hwp*

11. Industry or business

12. Name *Henry Rau*

13. Birthplace *Medford, Wis.*

14. Maiden name *Annie Rau Turner*

15. Birthplace *Medford, Wisconsin*

16. Informant *Mrs. H. Puraschintz*

Address *3603 Varnum St. Brentwood*

17. *Burial* Date thereof *Nov 26, 1948*

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *mt oak*

Location *Mitchellville Md*

18. Funeral director *F. Pasche sons*

Address *Myathville Md*

Nov 26 48 James Levy

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *11-23* 19 *48* at *9:50 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July* 19 *48* to *Nov 23* 19 *48*
 and that I last saw *pr* alive on *Nov 23* 19 *48*

Immediate cause of death *Carcinoma of Stomach* DURATION *8 mo*

Due to

Due to

Other conditions *Congestive Heart Failure 2 day*

(Include pregnancy within 3 months of death)

Major findings of operations *Carcinoma of Stomach*

with obstruction at esophagus Date of op. *Nov 18, 1948*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *L W Malin MD*

M. D. or other *Riverdale, Md* Date signed *Nov 24, 1948*

Address

RECEIVED

NOV 27 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11693

Reg. Dist. No. 248

1. PLACE OF DEATH:

County Prince GeorgesCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 hrs

Hospital, institution, or street address where death occurred:

Evergreen Island Memorial Hosp.How long in hospital or institution? 23 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Leesville
(If outside city or town limits, write RURAL and give nearest town)Street No. Crescent Cottages
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Don Ramirez

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Infant</u>
-----------------------	----------------------------------	---

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Nov. 2, 1948

8. AGE:	Years	Months	Days	If less than one day
				<u>23</u> hrs. — min.

9. Birthplace Evergreen Island Memorial Hosp. Riverdale Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Henry William Ramirez13. Birthplace Oklahoma14. Maiden name Mary Frances Surden15. Birthplace Iowa16. Informant Henry William RamirezAddress Crescent Cottages Leesville Md.17. Burial Date thereof Nov 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Bladensburg Md18. Funeral director L. Guehl SonyAddress Hyattsville Md19. Nov 4 19 48 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 19 48 at 3:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2 19 48 to Nov 3 19 48
and that I last saw him alive on Nov 2 19 48

Immediate cause of death

Premature Birth

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Berry M. D. or otherAddress Leesville Md Date signed 11-3-48

RECEIVED
NOV 6 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11694

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George

City or town Fairmont Hts
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6113 Kolb St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo

City or town Fairmont Hts
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6113 Kolb St
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

William Preston Rice

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

Negro

Widowed

8. (b) Name of husband or wife

Josephine Rice

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

APR 1869

8. AGE:

79

Months

Days

If less than one day

hrs. min.

9. Birthplace

Harrisonburg, Va
(Town, county, and state)

10. Usual occupation

Car painter

11. Industry or business

FATHER
MOTHER

12. Name

Ben Rice

13. Birthplace

Harrisonburg, Va

14. Maiden name

Not Known

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Paynes Dec 2/48

Location

Bennings Rd.

18. Funeral director

Address

In this Funeral Home

19.

11/30 48
(Date rec'd by registrar)

19.

Amanda Dourney
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1948 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 22 1948 to Nov 28 1948

and that I last saw him alive on Nov 11 1948

Immediate cause of death

Pulmonary

DURATION

congestion

Due to

Cardiac Failure

Due to

Hypertensive Heart Disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John W. Rount M.D.

M. D. or other

Address

515-South Ave
Fairmont Hts.

Date signed 11-28-48

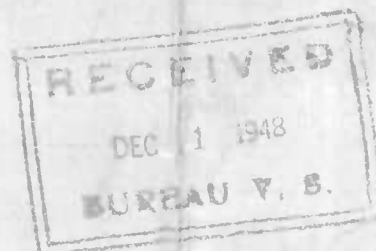
MARGIN RESERVED FOR BINDING

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VS A15 9-45-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1869
79
1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11695

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgesCity or town Brentwood Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)Street No. 4008 Shepherd st
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

Margaret Frances Roberts

3. (b) Social Security Number

none4. Sex Female5. Color or race white6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Everett H. Roberts6.(c) If alive, give age 85 years7. Birth date of deceased (mo., day, yr.) July 13 - 18658. AGE: Years 83 Month Day If less than one dayhrs. min. 9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Timothy Honohoe13. Birthplace New York14. Maiden name Ellen Morrison15. Birthplace Massachusetts16. Informant Mrs Marquiste MillerAddress Brentwood Md17. Burial Date thereof Nov 22, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. LincolnLocation Colmar Manor Md18. Funeral director F. Gasco's sonsAddress Hyattsville MdDate Nov 22 1948 James Seery Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19, 1948 at 12:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1945 to Nov 19 1948and that I last saw him alive on 11/17 1948Immediate cause of death Cancer stomach DURATION 1 yr

Due to

Due to

Other conditions Exhaustion 3 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Parkhurst MD M. D. or otherAddress 3100 20 NE Date signed 11/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11696 239

1. PLACE OF DEATH:

County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Three minutes

Hospital, institution, or street address where death occurred:

Warren's Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Howard

City or town High Bridge Laurel R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war World War #11

3. (a) FULL NAME

Albert M. Robinson

3. (b) Social Security Number

217-14-2043

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1922

8. AGE: Years Months Days If less than one day

26 0 15 hrs. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name George Robinson

13. Birthplace North Carolina

14. Maiden name Carrie Clark

15. Birthplace Maryland

16. Informant George Robinson

Address Laurel R.F.D.

17. Burial Date thereof Nov 20 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balt National Cemetery

Location Near Catonsville Md

18. Funeral director Ridgely Selby

Address 401 Wash Ave Laurel Md

19. Nov 19 48 M. Brashers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1948 at 8:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/16 1948 to 11/16 1948

and that I last saw him alive on 11/16 1948

Immediate cause of death

Acute laryngo tracheo -

bronchitis

Due to Streptococcal infection

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 11/16/48

RECEIVED

NOV 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11697

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Md. (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months, 13 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 3 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1721- 24th St., N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

RYAN, JOHN J3.(b) Social Security Number
(lost)

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) June 21, 1904 8.(c) If alive, give age _____ years
 8. AGE: Years 44 Months 5 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation House painter
 11. Industry or business _____
 12. Name Thomas P. Ryan
 13. Birthplace Baltimore, Md.
 14. Maiden name Cecelia Donnelly
 15. Birthplace Norfolk, Virginia

16. Informant deceased
 Address _____
 17. Burial Date thereof 11 27 48
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory St. Oliver Cemetery
 Location Washington, D.C.
 18. Funeral director Smith, Nelson
 Address 641 N. 1st N.E.
 19. Nov. 26, 48 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1948 at 1:40 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1948 to November 25 1948
 and that I last saw him alive on November 25 1948
 Immediate cause of death Pulmonary tuberculosis
 DURATION 3 yrs 9 mos.
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Daniel Leo Pinckney MD
 Address Glenn Dale, Md. Date signed Nov 25/48

RECEIVED

DEC 6 1948

BUREAU V. S.

100-100000-100000
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100-100000-100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11698

Reg. Dist. No. 245

1. PLACE OF DEATH:

County... Prince Georges
City or town... Riverdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

26 yrs.

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution?

9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince Georges

City or town... Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No... 4502 Riverdale Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Scott, Mr. William Edward, Sr.

3. (b) Social Security Number

4. Sex... male 5. Color or race... white 6.(a) Single, married, widowed, or divorced... married

6.(b) Name of husband or wife... Elsie Herron Hamill Scott

7. Birth date of

deceased (mo., day, yr.)

February 7, 1901

6.(c) If alive, give age... 49 years

8. AGE:

Years

Months

Days

if less than one day

47

hrs.

min.

9. Birthplace... Walden, New York

(Town, county, and state)

10. Usual occupation... Clerk

11. Industry or business... Veteran's Administration

12. Name... Walter F. Scott

13. Birthplace... New York

14. Maiden name... Emma F. Minard

15. Birthplace... New York

16. Informant... Hospital Records as given on admission

Address

17. Burial

Date thereof

Nov 16, 1948

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

Nov 16 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... November 14, 1948 at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 5, 1948, to Nov. 14, 1948

and that I last saw him alive on Nov. 13, 1948

Immediate cause of death

Acute pulmonary edema

DURATION

2 days

Due to

Coronary insufficiency

1 yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. A. Scharffenberg, M.D.

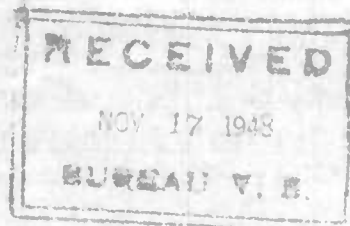
M. D. or other

Address

4404 Quince Orchard Rd., Riverdale

Date signed

Nov. 14, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
County..... Glenn Dale, Maryland
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 1 yr., 7 mos., 16 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution?..... 1 yr., 7 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 2925 Stanton Road, S. E.
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

WILLIE MAE SEWELL

3. (b) Social Security Number

578-26-4046

4. Sex Female
5. Color or race Negro
6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife..... John H. Sewell
6. (c) If alive, give age..... 58 years
7. Birth date of deceased (mo., day, yr.) March 28, 1899
8. AGE: Years 49 Months 7 Days 14 If less than one day..... hrs. min.

9. Birthplace..... Commerce, Georgia
(Town, county, and state)
Housewife
10. Usual occupation.....
11. Industry or business.....
12. Name..... John Wesley Segar
13. Birthplace..... Commerce, Georgia
14. Maiden name..... Mary Butler
15. Birthplace..... Commerce, Georgia

16. Informant..... Deceased
Address.....
17. removal Date thereof Nov. 12, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory.....
Location..... Washington, D.C.
18. Funeral director..... Walter E. Hunter Co.
Address..... 2425 Sheridan Rd., S.E.
19. Nor. 12, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1948, at 3:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1947, to Nov. 11, 1948, and that I last saw her alive on Nov. 11, 1948.
Immediate cause of death.....
Pulmonary Tuberculosis 2 yrs.
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?
23. SIGNATURE Daniel Leo Fineman M.D.
Address 98 Dab, Me Date signed 11/11/48

RECEIVED

NOV 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for correction of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11700

Film #118, November 17, 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
City or town Upper Marlboro, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2. (a) If veteran, name war —

3. (a) FULL NAME

Mathias Augustus Simmons

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Georgia Anna Simon
6. (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) April 2, 1864
8. AGE: Years 84 Months — Days — If less than one day — hrs. — min.

9. Birthplace St. Luke Marsh, Md. - Pr. Geo.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business at home

12. Name Mathias Augustus Simmons

13. Birthplace White Marsh, Md.

14. Maiden name Louise B. Breyer

15. Birthplace Pr. Geo. Co. Md.

16. Informant Harold Simmons

Address Upper Marlboro, Md.

17. Burial Date thereof 11 - 9 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MT. CARMEL CEMETERY

Location UPPER MARLBORON. MD.

18. Funeral director Robert L. McQuinn

Address 1820 - 9th St. N. W. Wash, D.C.

19. Nov 7 19 48 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 19 48 at 4:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to Nov 6 19 48
and that I last saw him alive on Nov 6 19 48

Immediate cause of death Acute Congestive heart failure + Cardiac Asthma
Due to Chronic myocarditis
Due to General Arteriosclerosis
Other conditions —

DURATION

1 day
within
return

(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following; —

Accident, suicide, or homicide — Date of —

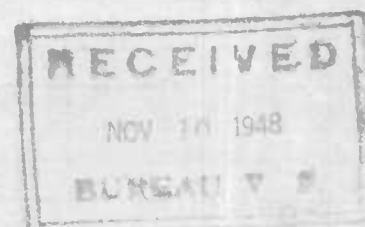
Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Phyllis H. H. H. M. D. —

Address Washington 1900 Date signed Nov 6



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County PRINCE GEORGESCity or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JESSICA-GRIFFITH-SMITH

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Charles Henry Smith7. Birth date of deceased (mo., day, yr.) March 31st 1891 6. (c) If alive, give age. years8. AGE: Years Months Days If less than one day
57 7 6 hrs. min.9. Birthplace Washington D.C.
(town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Edward Griffith
13. Birthplace VirginiaMOTHER 14. Maiden name Elda May Hall
15. Birthplace Long Island N.Y.16. Informant Charles C. Smith
Address 719 Hallwood Ave. Fbldh. Va17. Burial Date thereof Nov 7th 1948
(Burial, cremation, or removal; Which) (month) (day) (year)Cemetery or crematory Columbia GardensLocation Arlington, Va.18. Funeral director C. J. JonesAddress 2847 Wilson Blvd. Arlington, Va.19. Nov 7 1948 James Severy
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County ArlingtonCity or town Arlington
(If outside city or town limits, write RURAL and give nearest town)Street No. 1413 N. Barton St.
(If rural, give LOCATION)

2. (a) If veteran, name war.

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 7, 1948 at 1:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
OCTOBER 21, 1948 to NOVEMBER 7, 1948and that I last saw her alive on NOVEMBER 6, 1948

Immediate cause of death

DIABETES MELLITUS

DURATION

15 yearsDue to Chronic cardiovascular
renal disease - 3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

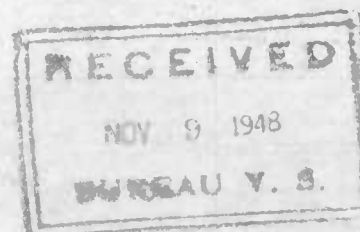
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Louis Mendel, M.D.
M. D. or otherAddress College Park, Md. Date signed 11/7/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2435

1. PLACE OF DEATH:

County md. PG
 City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

905- Karlson Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Hyattsville

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 905- Karlson Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

LULA J. STULTZ

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

74

hrs. min.

9. Birthplace

Bereton, Va
(Town, county, and state)

10. Usual occupation

House - Wife

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 2 1946, to Nov 23 1948
and that I last saw him alive on Sept 1 1948

Immediate cause of death

Carcinoma of colon

DURATION

3 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. I. or other

Address

Date signed

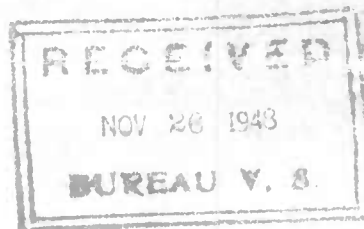
MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*De Maloney
agreed
H. H. H. H.
no 2 48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11703

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges
 City or town Hyattsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
4811 Braxton Pl. Hyattsville Md.
 How long in hospital or institution? 5

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County P. Georges
 City or town Hyattsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4811 Braxton Pl. Hyattsville Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Octavia Thomas

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband Charlie Thomas

7. Birth date of deceased (mo., day, yr.) March 2, 1880 6.(c) If alive, give age 64 years

8. AGE: Years 68 Months 8 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace St Marys Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business House

12. Name Ernest Dorsey

13. Birthplace St. Marys Co. Md.

14. Maiden name Unknown

15. Birthplace St. Marys Co. Md.

16. Informant Mrs. Irene M. Blufford Knight

Address 4811 Braxton Pl. Hyattsville, Md.

17. Burial, cremation, or removal. Which? Removal Date thereof Nov 9, 1948

Cemetery or crematorium W. Ernest Jones Co.

Location 1432 N. St. W. Wash D.C.

18. Funeral director W. Ernest Jones Co.

Address 1432 N. St. W. Wash D.C.

19. Nov 9 48 Jessie Semy Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1948 to Nov 9, 1948

and that I last saw him alive on Nov. 9, 1948

Immediate cause of death terminal pneumonia (apical) DURATION 4 days

Bronchial pneumonia

Due to Bronchitis 11 days

Due to _____

Other conditions Paralysis 1 day

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. su Date of _____

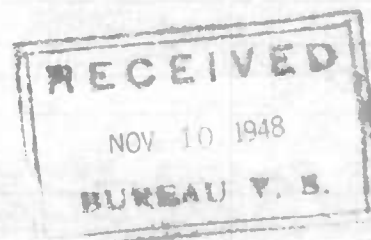
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm. H. Spiller M.D. M. D. or other _____

Address Brentwood, Md. Date signed 11-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11704

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince GeorgesCity or town Bowie
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Pr. GeorgesCity or town Bowie
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

4. Sex

F.

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

? About 1915

8. AGE:

33?

Months

Days

It less than one day

_____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business

MOTHER FATHER

12. Name John Carter (deceased)13. Birthplace Maryland14. Maiden name Elizabeth Scott15. Birthplace Anne Arundel County, Md.16. Informant Elizabeth WallsAddress Bowie, Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof Nov 27 48
(month) (day) (year)Cemetery or crematory Deer CreekLocation Bowie Pr. Georges Co18. Funeral director Martin Flodunsky SonsAddress Bowie Md19. Nov. 21 48
(Date rec'd by registrar)Two guests, Gingham
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 19 48 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____, to 19 _____

and that I last saw him _____ alive on 19 _____

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Coronary Sclerosis

Due to

Cardio-vascular renal disease

Other conditions

multiple adhesions all over body
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE John J. MaloneyDeputy Med Examiner
M. D. or otherAddress Cherry Hill, Md. Date signed 11-18-48

RECEIVED

NOV 26 1948

BUREAU V. S.

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11705
232

1. PLACE OF DEATH:

County Prince George'sCity or town Croome
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

East River Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Croome
(If outside city or town limits, write RURAL and give nearest town)Street No. East River Road
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

Orville Lee Walton

3. (b) Social Security Number

No.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary Walton7. Birth date of deceased (mo., day, yr.) April 4, 18886. (c) If alive, give age 50 years8. AGE: Years 60 Months 7 Days 25 If less than one day
.....hrs.min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Charles Walton13. Birthplace Virginia14. Maiden name Rose Stallings15. Birthplace Maryland16. Informant Mrs Mary WaltonAddress Croome17. Burial Date thereof Dec. 2, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory H. LincolnLocation Bladensburg, Md.18. Funeral director Ritchie BrosAddress 2125 Marlboro Rd19. Dec 1 19 48 Ritchie Bros
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

acute congestive heart failure
cardiovascular renal disease

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical examiner23. SIGNATURE Jasper D. Jones

M. D. or other

Address Thresholt Rd Date signed 11-29-48

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-4-15-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11706

Reg. Dist. No. 224

1. PLACE OF DEATH:

County **Prince Georges**
City or town **Andrews Air Force Base, (Wash 20), D.C.**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **1 year 6 months**
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **Maryland** County **Prince Georges**
City or town **Andrews Air Force Base**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **Qtrs 141 Apt # 4**
W W II
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Meinzen, Robert Willfred

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Married**

6.(b) Name of husband or wife **Karen M. Meinzen**

7. Birth date of deceased (mo., day, yr.) **12 Feb 1924** 6.(c) If alive, give age years

8. AGE: Years **24** Months **9** Days **8** If less than one day hrs. min.

9. Birthplace **Honolulu T.H.**
(Town, county, and state)

10. Usual occupation **U.S. Air Force Officer**

11. Industry or business **U S Air Force**

12. Name **Lawrence Meinzen**

13. Birthplace **Woodburn Ind.**

14. Maiden name **Mrs Edna Markworth**

15. Birthplace **Waymensville, Ind.**

16. Informant **Army records**

Address

17. Burial Date thereof **Nov 24 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Arlington Nat. Cem.**

Location **Arlington, Va.**

18. Funeral director **Walter Funeral Home**

Address **301 E. Capitol St., Washington D.C.**

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **20 Nov 48** at **1320 P.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h alive on **Never**

Immediate cause of death **Crushing injuries**

generalized entire body with

Evisceration

Due to **Crash of F-80 aircraft at**

Andrews Air Force Base, Prince

Georges County

Due to **at about 1320 hours 20 Nov 48**

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **Aircraft accident** of **20 Nov 48**

Where did injury occur? **Andrews AFB, Wash 20, D. C.**

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **Work**

Means of injury Injured at work? **Yes**

23. SIGNATURE **FRANCIS E. BARRY, Captain, MC**

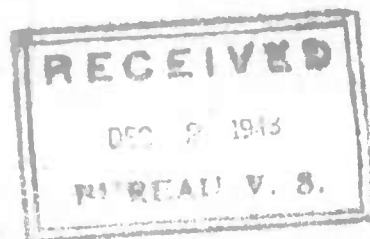
M. D. or other **20 Nov 48**

Address **Andrews A.F.B.** Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11707

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 4 mos., 20 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 4 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 2408 Eye Street, N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

SAMUEL L. WILLIAMS

3. (b) Social Security Number

251-36-8732

4. Sex..... Male
 5. Color or race..... Negro
 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Marie Williams

7. Birth date of deceased (mo., day, yr.)..... August 14, 1927
 8. (c) If slave, give age..... 20 years

8. AGE: Years..... 21 Months..... 3 Days..... 8 It less than one day..... hrs. min.

9. Birthplace..... Washington, D. C.
 (Town, county, and state)

10. Usual occupation..... Parking Lot Attendant

11. Industry or business..... - - -

12. Name..... Sam Williams

13. Birthplace..... ? South Carolina

14. Maiden name..... Costella Booker

15. Birthplace..... ? South Carolina

16. Informant..... Deceased

Address.....

17. Removal to Washington, D. C.
 (Burial, cremation, or removal. Which?) Date thereof..... Nov 22 1948
 (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director..... J. J. Jones

Address..... 1324 1st St. N.E.

Nov 22 1948 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 22nd 19. 48 st 4³⁰ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 19. 48 to Nov 22nd 19. 48 and that I last saw him alive on Nov 22nd 19. 48

Immediate cause of death.....

Pulmonary Tuberculosis
 DURATION 1 yr 9 mos

Dus to.....

Dus to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Daniel Leo Lineweaver MD

Glenn Dale, Md. Date signed..... Nov 22/48
 M. D. or other

RECEIVED TO THE ATTORNEY GENERAL

RECEIVED TO THE ATTORNEY GENERAL

RECEIVED

DEC 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11708

131a

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince George'sCity or town Clinton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Clinton
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name was World War I.

3. (a) FULL NAME

James Edie Needie Windsor

3. (b) Social Security Number

?

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Grace Windsor6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) Oct 14, 1891

8. AGE:

57 Years- Months11 Days

If less than one day

hrs. min.

9. Birthplace

Maryland - Piscataway
(Town, county, and state)

10. Usual occupation

mechanic

11. Industry or business

land and fine plant

FATHER

12. Name

Ignatius Windsor

13. Birthplace

Maryland

MOTHER

14. Maiden name

Camelia Jenkins

15. Birthplace

Maryland

16. Informant

Grace Windsor

Address

Clinton, Md.

17.

Burial

Date thereof

Nov. 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington, Va.

18. Funeral director

Ritchie Bros

Address

Upper Marlboro, Md.

19.

Nov. 6, 1948

19.

Mrs. Elton Davis

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 19 48 at 4:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Intra cranial hemorrhage

DURATION

Due to

Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

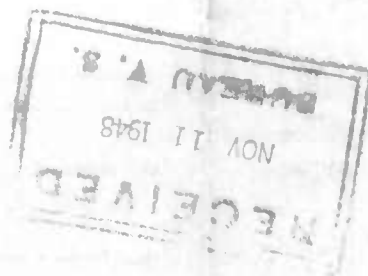
Deputy medical examiner

23. SIGNATURE

Thesell

M. D. or other

Date signed 11-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11709 232

1. PLACE OF DEATH:

County Prince George's
 City or town Upper Marlboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Upper Marlboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 710
 (If rural, give LOCATION)
 2.(a) If veteran, name war 710

3. (a) FULL NAME

James Ernest Wright

3. (b) Social Security Number

None.

4. Sex male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Mary E Wright
 6.(c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) Sept 21, 1891
 8. AGE: Years 57 Months 1 Days 26 It less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business
 FATHER 12. Name Benjamin Wright
 13. Birthplace Maryland
 MOTHER 14. Maiden name Sarah Tyler
 15. Birthplace Maryland

16. Informant Mary E. Wright
 Address Upper Marlboro, Md
Burial Date thereof Nov 20, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Phillips
 Location Aquasco, Maryland
 18. Funeral director Ritchie Bros.
 Address Upper Marlboro, Md
Nov 18 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at 9:20 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19... 19...
 and that I last saw him... alive on... 19...
 Immediate cause of death Intra cranial hemorrhage
 Due to Cardiovascular renal disease
 Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Deputy Medical Examiner Injured at work?
 23. SIGNATURE James E. Wright M. D. or other
James E. Wright Date signed 11-18-48
 Address... Date signed...

RECEIVED

NOV 19 1948

BUREAU V. S.